Extending Social Protection through Health Micro-Insurance Schemes to Women in the Informal Economy

(RAS/01/02/MNOR)

Module 1

Reference Guide and Tools on Health Micro-Insurance Schemes in the Philippines

Health Micro-Insurance Schemes in the Philippines

STEP Strategies & Tools against Social Exclusion & Poverty

International Labour Organization
Subregional Office for
South East Asia and the Pacific

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MODULE 1

Purpose

The purpose of this module is to provide you with an overview of social protection in the Philippines in general and of health micro-insurance scheme in particular.

The first part of this module hopes to help you understand better the rationale and importance of social protection in the Philippines as a response to the risks and vulnerabilities faced by individuals, particularly those working in the informal sector. It aims to clarify what social protection in health is and lists the different mechanisms that exist, the services and benefits they offer as well as their limitations.

Recognizing the limitations of the existing health protection schemes, the second part of this Module introduces you to health micro-insurance as a promising mechanism for extending health services and care to those working in the informal economy. It aims to improve your understanding of the key features of a health micro-insurance scheme and equip you with significant information vital to its efficient and effective operation. By reading this Module, it is hoped that you will be able to fully understand the rationale, principles and the basic features of a health micro-insurance scheme before setting up one as discussed in the next Module.

Content

Module 1 starts with the discussion on the importance of social protection in health by presenting the risks that any individual faces, giving emphasis to sickness-risk and explaining why men and women working in the informal economy are more vulnerable to these risks. With this introduction, the Module then describes the various ways adopted by individuals in coping with these risks, the nationally designed institutions-based schemes and non-conventional mechanisms initiated by community groups and orgnizations. The Module describes their limitations and introduces health micro-insurance as a tool for extending social protection to men and women working in the informal economy.

The Module then segues way to defining what is a health micro-insurance scheme and expounds on the key principles and approaches that govern its formation and establishment. It presents the basic elements that make it up as a whole system. These elements include the organizational structures to be formed, the categories of beneficiaries that patronize its services, the types of services it offers and the mechanisms for membership application, payment of contributions, granting benefits and availing of these benefits. This module ends up with the presentation and discussion of various risks associated with health micro-insurance scheme and the ways by which these risks can be minimized.

Sections

1.1.1 Various Risks An Individual Faces

As individuals, men and women alike, you are exposed to a range of risks. When these risks occur, you incur corresponding losses. These risks vary in degree or magnitude depending on the type of work you are engaged in, the setting where you work and the level of hazard attached to your work.

The term "risks" relate to the possible occurrence of a future event, usually an undesirable one, against which you must be protected. The exposure to risk is undoubtedly part of the human condition. Sources of risk are diverse, and all populations are susceptible to adverse shocks resulting from natural, health, social, economic, political, and environmental risks. Depending on the number of individuals or households that are simultaneously affected, risks are either idiosyncratic (individual) or covariate (aggregate). As the terms imply, idiosyncratic risks are those that occur when only one or a few individuals or households in a community suffer losses, whereas covariate shocks affect a large number of households, entire communities, regions within a country, or countries. Some of these risks may result from acts of nature, whereas others are caused by human activity. These risks are not evenly distributed among all men and women, hence people are equally exposed.

Certain individuals and groups have a much higher exposure to risk than others because of socio-demographic characteristics, economic status, physical or mental condition, age, lifestyle and so forth. Vulnerability is a state of high exposure to certain risks, combined with a reduced ability to protect or defend oneself against those risks and cope with their negative consequences.

Examples of risks occurring at the individual level include those associated with health, such as illness, disability, old age, death, or social shocks such as crime and domestic violence. Aggregate risks affecting large populations can include natural disasters (earthquakes, floods), health epidemics (HIV/AIDS), environmental calamities (pollution), political (Coup d'État) or economic (financial crisis) risks.

1.1.2 Sickness As A Risk

Sickness is a risk whose scope goes beyond health matters. An illness may imply a serious financial burden, it is not possible for you to know in advance the expenses you may need to pay or when you need to pay for such expenses. Sickness may cause lasting and sometimes irreversible damage to your health. It may incur major material losses. Sickness can lead to incapacity for work, either temporary or permanent, with consequent loss of earnings. Oftentimes, sickness also affects your significant others who will care for you. In Philippine society, it is usually women - mothers, grandmothers, sisters, daughters, daughters-in-law, aunts - who are expected to perform this role. Other than having additional responsibility, sometimes it also prevents them from performing their regular activities, including attending to their paid work.

(a) *Categories of Sickness Risk*: In financial terms, sickness risks are usually broken down into two categories:

(a.1) *Major Risks:* These include the risks connected with serious illness and, more generally, complaints that require expensive care like hospitalization, surgery, and other specialist care. The probability that these events will occur is low but, when they do, the costs involved are beyond the means of most families. Few individuals are in a position to bear the full financial burden of such costly care, particularly if they have to seek the services of distant care providers.

(a.2) *Minor Risks:* Minor risks relate to the lesser ailments that require less expensive care but which occur far more frequently than the major risks. This category includes, for example, nursing care and outpatient consultations.

You are well advised to protect yourself, in order to reduce this risk. In insurance, this risk associated with sickness is called the "sickness risk". If you, as an individual are not insured, you may not be able to shoulder the expenses involved in your recovery, thus compounding the effect of the illness on your health.

(b) *Implications of Sickness:* Sickness implies financial costs or burden on your part and your family and it is usually the root cause of poverty. Sickness increases the financial burden of you and your family and its occurrence aggravates conditions of poverty. The financial as well as psychological burden of being sick or caring for a sick family member could further prevent you and your family from engaging in productive work.

(b.1) *Limited coverage*: The financial burden of your sickness is manifested by your capacity to access treatment. If you have limited means, your access to health care is reduced. Your non-coverage comes in different forms depending on the sources and level of your income as individual and your family.

(b.1.1) *Economic limitations:* This means your inability to afford health care expenses due to lack or insufficient income you have throughout the year.

(b.1.2) *Financial limitations:* This means that even if you have earned some income, it is not always regular, hence, you are limited due to this financial constraint:

- Temporary limitation occurs when your family does not immediately have the necessary means to pay sickness-related expenses, which consequently delays your seeking of care
- Partial limitation happens when you do not have enough means to pay for all the care and treatment required or prescribed
- Seasonal limitation exists when your income fluctuates over the year. For example, if you are in the rural area, your income is often concentrated only during one or several periods, corresponding to the time when you sell your crops. In this case, you encounter major difficulties during the rest of the year in paying health expenses, even for minor ailments. Men and women workers are not exempted from seasonal variations.

(b.2) *Poverty:* Sickness is frequently at the root of long-term poverty, particularly when:

- you or your spouse, who is the breadwinner dies or becomes disabled, for lack of care
- your family incurs a large debt to pay a substantial and urgent health care expense, usually to a moneylender, or sells an asset, notably a production tool, at a hugely reduced price

1.1.3 Vulnerabilities of men and women workers in the Informal Economy Workers to Risks

It has been mentioned that no one is exempt from risks, but those of you in the informal economy are most vulnerable to them given your unsuitable working conditions and poor situation.

(a) *Characteristics of Workers in the Informal Economy*: Given the very nature of your work as home-based workers, construction workers, market vendors, transportation workers, ambulant vendors, sari-sari store owners, small farmers, fisherfolks and forest dwellers, and

many others, it is understandable why you are more vulnerable to risks. As workers in the informal economy, you are generally economically poorer and are more frequently subjected to financial risk connected with illness. Majority of you frequently live "from hand to mouth" and cannot always devote part of your income to provident measures and actions for health and education. The non-regularity of your income and the seasonal fluctuations of your earning levels also limit your capacity to access health services on a regular basis.

(b) *Working Conditions in the Informal Sector:* Your working conditions in the informal economy are generally characterized by poor welfare facilities, unsanitary and cluttered surroundings, lack of potable water supply and poor lighting. This is primarily true for you as home-based workers. Since your work is most often done near or within your homes, your entire family is also greatly exposed to the same risks of illness and accidents.

Those of you in the manufacturing and construction are exposed mainly to accidents. Fire or electric-related accidents were found highest among you who are working in restaurants, personal and household services as well as in food and beverage retailing. Machine-related accidents occur mainly in manufacturing, repair services, other trades and construction work. Accidents due to falls are mostly found in construction. In the agricultural sector, risks are often related to sudden changes in the season/climate and the threats of natural calamities and pests infestations.

For women like you in the informal economy, the working conditions aggravate your risks to illness or sickness. The type of work you are mostly engaged with (e.g. laundry washing and ironing, sewing, selling food or merchandize on the street and in the market) usually entails very long hours of work, thus exposing you more to suffer psychological and physical stress as you strive to balance your responsibilities both at work and at home (and in the community, such as volunteering as a barangay health worker or para-teacher).

Your working children on the other hand, are found in many work situations where they suffer working conditions similar to or even worse than you are exposed to as adults. These are characterized by long working hours, unhealthy environment and hazards in the workplace which stunt their growth and development.

1.1.4 Increasing Magnitude of the Informal Economy

All over the world, there has been a significant increase in the number of people working in the informal economy while more formal enterprises have been subcontracting mostly their production and service requirements to you as external providers. Self-employment, casual or contractual arrangement or part-time jobs are now becoming the typical form of work arrangements, which is quite the opposite 15 or 20 years ago.

The trend towards flexibilisation of labour in response to competitive pressures on the global market has resulted in the growth of "atypical" or "non-standard" forms of employment such as part-time or home work. Home workers are vulnerable to exploitation and often excluded from the protection and benefits afforded by labour legislation.

In the Philippines, the proportion of people like you becoming self-employed, casualized and contracted for part-time or piece meal work is steadily growing for the past years. There are about 19.0 million workers like you now working in the informal economy, representing over 50% of total employment population. Women are highly represented among informal economy workers - especially in poorer segments, in worse conditions or at lower or no wages; they engage in such activities because of the need to combine

family responsibility with jobs and because of the lack of other income-earning opportunities.

With this growing size of the informal economy, more and more people like you are being exposed to the above-mentioned risks. Hence, there is a need to parallel this increasing magnitude with the corresponding expansion and coverage of responsive social protection services.

1.1.5 Reasons for Social Protection Services

There are significant reasons why social protection must be made available and accessible to those of you working in the informal economy and to the working population in general. Given the risks and vulnerabilities you face in your work, it is necessary that you should be covered with social protection schemes and have access to their services at the time you need them and at the cost you are able to afford.

First, you must note that social protection is considered as your basic human right. It is a core need that must be made available to every worker like you in all society, whether you are working in the formal or informal sector. At the same time, the basic labor standards require that your welfare as workers must always be considered and that measures of protection should be made available to you regardless of the kind of work you are asked to do. If social protection is your basic human right and an integral component of the labor standards, then this must be provided for by the government and adhered to by the concerned enterprises you are working with.

Secondly, the absence of social protection makes you in the informal economy most vulnerable to any adverse condition that might occur in the course of your work. If as a worker, you are immobilized due to sickness, your productivity is reduced, resulting to a drop in your earnings, which in turn makes it more difficult for you to pay for health care and treatment. Social protection is essential to cushion you from the grave impact of these adverse conditions.

Third, the lack of social protection incurs higher cost on your part as workers. It has been shown that when you are not insured against illnesses or disasters, the cost you spent during this time of need is much higher than when you should have provided for these services in the first place. Social protection therefore is a cost-effective way of responding to your needs

Lastly, the lack of social protection results to your reduced productivity, and thus delaying the overall economy of the country altogether. Providing social protection and ensuring your security as individuals are expected to bring about better productivity in the workplace and throughout the economy.

1.2.1 Social Protection in Health

There are different interpretations and definitions of the term "social protection." Some define it to mean the sum of social security fund activities while others define it to be any activity of a social nature to constitute social protection.

This guide considers social protection to refer to the coverage provided by society or by an organization to its members, through a series of public measures for the following purposes:

- to compensate for loss or significant drop in earnings in a series of contingencies (examples are sickness, maternity, occupational accident or disease, invalidity, old age, death in the family breadwinner and unemployment)
- to provide health care
- to provide assistance to families with children

Social protection in health refers therefore to any coverage provided by any institution or organization to its members that addresses the health needs of its members and their families. This coverage may take various forms of health activities and services.

At this point, please take note that this guide is mainly concerned with the social protection in health and is focused to those in the informal economy.

1.2.2 Coping Mechanisms To Sickness Risks

It is known that you and your families cope with various risks differently. There are some of you who make use of traditional or usual mechanisms to cope with these risks. Others are engaged in pre-payment and insurance schemes when these events occur. You, as individuals and your families, have usually two alternatives for coping with sickness risks:

(1) You can either wait until a sickness occurs and then try to raise the necessary means to pay your health care expenses, or

(2) You can take steps to be ready to cope with such expenses before a sickness occurs

In the first one, you do not seek protection against the risk but simply deal with the financial repercussions at the time the sickness occurs. The uncertainty remains high whether you will be able to cope with the costs or not. Oftentimes, women who are tasked with taking care of the sick, are also burdened with borrowing money from creditors, because of the common perception that women are more likely to honour their promise of payment. In the second case, you anticipate the financial implications of sickness. It is possible for you to meet the costs of sickness more readily. It is a provident way of protecting yourself against the sickness risk.

In all societies, majority are averse to risk like you. It is for this reason that a number of people have developed provident mechanisms to protect themselves against risks. These mechanisms have been perfected over time, particularly with the development of insurance, which is the most effective instrument of protection against risks. The following shows you the different ways of coping with the sickness risks as individuals and as a group.

Table 1.1: Different Ways of Coping with Sickness Risks

Usual and Traditional Alternatives	Prepayment and Insurance Systems	Other Alternatives
As Individual		
✓ Loan from a moneylender ✓ Sale of assets (livestock, furniture, tools, jewellry, ✓ Use of shop or workshop funds ✓ Using credit not for its original purpose ✓ House keeping – engage in laundry, ironing and other housekeeping services for other families or households	✓ Loan from a moneylender ✓ Membership to prepayment mechanisms (without risk-pooling) • Saving/health credit • Health Subscription	✓ Traditional medicine ✓ Self-medication, purchase of drugs from a shop or market
As A Group (collective)		
✓ Recourse to mutual aid and solidarity within the family or between friends/ neighbours: loans and/or gift ✓ Participation in a mutual aid association	✓ Membership an insurance scheme • Social Security • Commercial Insurance • Not-for-profit Insurance • Health Micro Insurance	

1.2.3 Existing Schemes of Social Protection in Health

The Philippines has established national schemes on social protection designed for workers in the formal economy. Of these, two have programs that can cover health-related risks of the informal economy workers.

(a) *Social Security System (SSS):* This offers a comprehensive cash benefits as insurance for disability, maternity and sickness and provides benefits for retirement, old age and death. It

also offers low interest loans during calamity, emergency situation, housing and educational loans paid through salary deductions.

The SSS in 1995 has extended its membership to the informal sector under its self-employed and voluntary membership program. Under this scheme, the minimum monthly salary required to qualify as SSS member was lowered to Php 1,000. Definition of self-employed was expanded to include "all self-employed persons regardless of trade, business or occupation, with a monthly net income of at least Php 1,000." It includes household help, individual farmers, fisherfolks and other small entrepreneurs wanting to join the scheme on a voluntary basis.

The monthly contribution to SSS is set at Php 84.00 and paying this amount regularly for at least 1 year entitles the member to sickness, maternity, disability, retirement and death benefits including service loans like salary, calamity, stock investment and special education loan. Enrolment to the self-employed scheme of SSS requires the submission of duly accomplished forms which include: (a) birth certificate, (b) business license/permit for single proprietor and professional regulations commission for professionals. These requirements are viewed to exclude those persons working with no clear employer-employee relationship and those self-employed with income less than Php 1,000 but whose businesses have not been registered with any government agencies.

(b) *Philippine Health Insurance Corporation (PHIC or PhilHealth):* The PHIC, established in 1995 is mandated to administer health care contributions and to develop a health insurance system that will ensure affordable, adequate and accessible health care services to all Filipinos. Medical services are obtained from accredited service providers and facilities and medical expenses are reimbursed using a ceiling of fees pegged according to the severity of illness suffered by members or qualified dependents.

PhilHealth, just like the SSS, has also created a mechanism to enrol the self-employed. This allows members in the informal economy to pay contributions in order to access health benefits. Two programs are found relevant to the informal sector: (a) the Individually Paying Program (IPP) and (b) the Indigent Program.

The IPP focuses on the self-employed and the informally employed. Individuals are required to pay Php 100.00 as monthly contribution regardless of income. This amount entitles them coverage for room and board, laboratory tests, medicines and doctor's fees when confined in a hospital. The benefits though depend on the category or type of illness, type of hospitals and type of medical services received.

The Indigent Program (IP) on the other hand focuses on enrolling the poorest 25% of the population of each province or municipality. This program requires the consent and participation of the local government units (LGUs) who provide the counterpart contributions together with the national government. Aside from being entitled to the same benefits as members in the IPP, members can avail of the Out-Patient Benefit Package (OPB) from accredited Rural Health Units (RHUs).

Other agencies like the Employees Compensation Commission (ECC) or the Government Service Insurance System (GSIS) also offer social protection for health like insurance from accidents in the workplace for ECC and health benefits like maternity, disability and sickness for GSIS. However, both agencies do not have programs that would cover informal economy workers.

(c) *Non-Conventional and Indigenous Mechanisms*: There are also other forms of social protection in health which consist of the non-formal, non-conventional and indigenous mechanisms that have evolved in communities, people's organizations, cooperatives and civil society groups. These schemes are rooted in the traditional forms of family and community support namely: the "bayanihan" and "damayan". In times of economic and social need, Filipinos traditionally seek help from their families, relatives, friends and community. Several efforts are being undertaken to institutionalize these schemes.

For health care, some schemes cover free check-ups and outpatient consultations. In some cooperatives, free medicines are given and partial reimbursements are also provided to help defray hospitalization, laboratory and surgical costs. There are some cooperatives with large base of members who maintain a small clinic and hire medical staff to render preventive and curative care. In a few cooperatives, dental care in the form of tooth extraction, oral prophylaxis and tooth filling are provided.

Under these schemes, more formal means of collecting premiums are established for a specific set of benefits. Examples of these are the Guimaras Insurance Program and the Organizing Resources for Education and Training (ORT) Health Plus Scheme (OHPS).

These non-conventional schemes have some advantages over the formal schemes. They offer more affordable premiums or contribution rates, they have more flexibility in the forms of payment, they have simple and straight forward procedures and benefit packages focused to what they really need.

1.2.4 Limitations of the Existing Schemes of Social Protection in Health

It must be noted that social protection in health emerged from the concern that majority of workers like you are beyond the scope and coverage of the institutional social security systems (e.g. PhilHealth, SSS, ECC, etc.). The large poor segment in the work force is unable to abide by the principle of contribution on a regular basis as required by these institutional-based security systems. There are more forms of limitations imposed by these formal schemes. The same is true for the non-conventional indigenous schemes. These limitations are discussed below:

(a) *Limitations of Social Protection in Health in the Formal Economy*: The institution-based schemes have limited coverage. The SSS for example, excludes those workers with unclear employer-employee relationship and those self-employed earning less than Php 1,000. and those who have not registered their business with the appropriate government agencies. Secondly, SSS and Phil Health collection centers are found mostly in the cities. This is difficult for voluntary members who may have to go to distant locations to pay their contributions. In addition, these schemes are also weakened by the following factors:

- limited levels of security
- fragmented institutional framework
- lack of a comprehensive financial analysis
- low participation of workers in the informal economy due to:
    - absence of employer-employee relationship
    - low and unstable incomes
    - lack of awareness of social security rights
    - satisfaction with indigenous social schemes
    - complex policies and procedures
    - inappropriate and inadequate health benefits

(b) *Limitations of Non-Conventional Indigenous Schemes:* The basic limitations of these schemes are the limited scope of support that can be provided by the families and friends and the unsustainable nature of the support. There is no assurance that help will always be available. Resources are also limited, inadequate and may not always be forthcoming. These informal schemes have certain advantages but they have also limitations. On the other hand, their limitations include the small size membership, their lack of technical expertise and lack of marketing and information dissemination activities.

In the Philippines, several groups have ventured into health micro-insurance scheme (HMIS) initiatives as a form of social protection in health. Because of the increasing cost of health care, the inaccessibility of health services, and the inability of individual workers to participate in the formal health insurance systems, many groups have began to establish their own mechanisms to meet their health needs. HMIS are a promising alternative for overcoming barriers of access to health care in the informal economy.

Section 1.3: Health Micro-Insurance Scheme As a Social Protection in Health

HMIS in the Philippines are viewed though as an interim arrangement in extending social protection to men and women in the informal economy until such time that they could be mainstreamed with that of the National Health Insurance Program (NHIP). Existing HMIS can be mainstreamed when they are made to function as an extension of the NHIP in terms of service provision, collection of fees or a complementation of services to be made available to the members. There is a great potential in the country for these local or community risk pooling schemes (e.g. HMIS) to be integrated with the national schemes into one system. Increasing therefore the capacity of HMIS helps to prepare them for this integrated set-up with the National Health Insurance Program (NHIP) which is managed by Phil Health.

1.3.1 Goal of Health Micro-Insurance Scheme

HMIS are aimed at women and men who are not reached by the formal health protection schemes or those set up by the government or offered by commercial companies. The goal of HMIS is to allow each member and their dependents to have access to quality health care. The HMIS are therefore intended above all to bring down financial and if necessary, geographical barriers hindering access to such care.

1.3.2 Forms of Health Micro-Insurance

HMIS cover a wide range of activities intended for the dis-advantaged groups not covered by mandatory health insurance and who do not have access to the usual commercial insurance. These are set-up to respond to different levels of risks and are operated by different actors like non-government organizations (NGOs), community organizations and other types of groups.

(a) *Insurance supplied by care providers:* A health center or hospital may suggest that potential users pay a contribution entitling them to care, either free of charge or at a reduced cost. Usually the members of this scheme are not involved in managing the system.

(b) *Health insurance schemes provided by micro-finance institutions*: This form offers their members supplementary services such as life insurance or an emergency health fund.

(c) *Mutual Health Pharmacies*: These are managed by non-profit-making organizations that favour members who contribute to a mutual fund. In general they mainly deal in essential

generic medicines. In the Philippines, several groups have set up community-managed pharmacies or "*botika sa barangay*" to respond to the need for quality medicines at an affordable cost.

(d) *Other forms of not-for-profit insurance:* This may involve, for example, a transportation insurance operated by a group which owns an ambulance. Membership is either voluntary or compulsory (the contribution in the latter case is collected in the form of a tax), and the funds collected ensure free or reduced-price service for emergency transportation. The purpose is to finance the operating cost of the vehicle.

1.3.3 Advantages of HMIS

The advantages of an insurance system for its beneficiaries are:

(a) *Greater security in the event of sickness for members and their dependents*: By paying an amount that is known in advance and on a planned basis (daily, weekly, etc.), your members will not have to assume exceptional expenses which may be very high when unforeseen situations arise.

(b) *Better continuity of treatment*: The number of recourse to care during the period covered is not limited or confined to a single period of sickness, and your beneficiary enjoys greater facility of access to necessary care.

(c) *Reduction of delay in seeking care*: Your members benefit from free care or with slightly reduced prices. Access to care is therefore not anymore or fairly less delayed while your affected member raises the necessary funds.

(d) *Reduction of financial limitations*: The forms of limited coverage connected with lack of money at the time of sickness are reduced because the sums to be paid for care are small or non-existent. Your member is assured of access to health services even during periods of greatest financial hardship (low cash season, festivities and ceremonies, etc).

(e) *Reduction of parallel practices:* Your member is informed of the share of the health care bill that they will eventually be required to pay to the health center or hospital. Consequently, relations with the health care provider are more transparent and there are fewer possibilities of parallel practices (unlawful receipt of money by health staff).

1.3.4 Characteristics of a HMIS

Majority of HMIS in the Philippines for the informal economy workers, are programs of existing cooperatives, people's organizations (POs), mutual organizations and NGOs which have mobilized their group's resources to set up a their own schemes. Most of these have included health services as part of the package of social protection benefits they provide to their members. The following are the basic features of an HMIS. You can verify if your HMIS possesses the following characteristics or if you are planning to set-up one, ensure that it should have the following features:

(a) *The HMIS Has An "Insurance Function":* One of the basic features of HMIS is it functions as an insurance. This means that your members obtain a guarantee from your HMIS that they will receive financial reimbursement, or that they will be covered, should the sickness risk occur.

(b) *Financial Participation:* The members or beneficiaries of your HMIS pay their contributions,

at least in part to finance the benefits they get from your HMIS.

(c) *Non-Compulsary Membership:* The beneficiaries of your HMIS are insured on a voluntary or automatic basis. This means that your members were not coerced to join. Their participation or membership is not compulsory. In some HMIS, the membership becomes automatic. This is true for example, for individuals working in an organization or is a member of an association that is already enrolled in an HMIS as a whole group.

(d) *Non-Coverage From Social Security:* Your beneficiaries are in part or at least individuals who are excluded from the national social security system or whose earnings are below the poverty threshold that are fixed nationally. Though this should not limit your organization from accepting members who are also members of a national social security scheme.

(e) *Involvement of Beneficiaries in the Management:* The members or beneficiaries of your HMIS are involved or participate in the management of your insurance scheme, or at least in the selection of health services to be covered.

(f) *Complement to Formal Social Security Systems:* Some HMIS are established to complement the formal social protection schemes. It means that your HMIS are those not usually covered by these formal institution-based mechanisms. Note however that there are also some HMIS which have been established by some organizations in lieu of these schemes. For example, some organizations are still hesitant to participate in PhilHealth or SSS for a variety of reasons. In short, they cover and offer services which are also provided by the formal sector. Caution should be taken though in going to a similar path, reasons for not participating in the national schemes should be carefully evaluated and weighed.

(g) *Legal Personality:* Your HMIS is usually operated by a non-profit voluntary association of people, operating on the basis of solidarity among all members. Through your members' contributions, and according to their decisions, your HMIS provides insurance, mutual aid and solidarity measures to insure them against the risk related to illness, bear the consequences and promote health. It is important however that your HMIS must have a legal personality. This means that it should either be registered in the Securities and Exchange Commission (SEC) or under the Cooperative Development Authority (CDA). Having a legal personality means that your HMIS is licensed to operate, allowed to enter into a Memorandum of Agreement (MOA) with concerned entities and that it can collect and accept financial contributions as an organization.

1.3.5 Basic Principles of a Health Micro-Insurance Scheme

The following are the basic principles which you must observe in establishing and operating your HMIS.

(a) ***Solidarity:*** Your HMIS must be rooted on solidarity, or the spirit of " bayanihan" or "damayan". Your membership is neither compulsory nor dependent on the state of health of your future members. Through solidarity, the members of your HMIS express their desire to deal with their problems themselves by assisting each other. Their contributions signify the principle of mutual assistance and solidarity within the organization. This means that your members who are in good health and accept that their contributions are used to cover the expenses of other members who are ill. It entails pooling of these risks among themselves. On the other hand, solidarity also means that your individual member who fails to give his/her regular contributions cannot receive benefits from the scheme. Solidarity means the willingness of your members to

contribute and that they allow their contributions to be pooled together in response to risks that anyone of them might encounter.

(b) ***Democratic and Participative Operation:*** In your HMIS, everybody must be free to join without racial, ethnic, sexual, religious, social or political discrimination. All your members should have the same rights and duties. These include the right to participate, directly or indirectly in the decision-making process. Participative democracy in your HMIS is evidenced by your formation of organizational structures or bodies which allow your members to participate in decision-making and in controlling your HMIS operations. Your members therefore have to be made fully aware of their duties and responsibilities. This can be done through appropriate training, supported by clear, complete and readily understandable information.

(c) ***Autonomy and Freedom:*** Autonomy as a principle in your HMIS means that any public authority or any other party (political or religious groups, service providers) should not interfere in your management and decision-making process as an organization. It does not mean though that your HMIS is not subject to laws and regulations. Your HMIS should comply with these national laws and regulations but it should not allow its decisions and programs to be dictated upon by politicians, businesses or other groups with strong influence. Freedom, on the other hand, means that your members are free to decide what services your HMIS should offer or that they have the flexibility to modify them according to what they most need. This right usually leads to more efficient use of your resources.

(d) ***Personal Fulfilment:*** In addition, your HMIS must espouse respect for the dignity of your individual members regardless of gender, race, ethnic or social origin. As an HMIS, you must encourage your members to become truly socially committed to the sick and the most destitute.

(e) ***Service-Oriented:*** Your HMIS should devote its time to serving your members and not in making profit. It does not mean though that covering for operating expenses is not allowed in your HMIS. The extra income that your HMIS earned over expenditure can be used to improve your existing services, or to meet the other needs of your members.

(f) ***Responsibility:*** While your HMIS emphasizes solidarity, autonomy and participative democracy, it equally underscores the importance of responsibility. All the rest of principles will come to nothing if your members and leaders are not mindful on the way they use your HMIS resources or do not respect the decisions which you have collectively agreed-upon.

(g) ***Dynamics of a Social Movement:*** Your members are characterized to be pro-active, not passive. They must become committed to an individual and collective development process and that your members are group of individuals who seek to defend the common good and common interests of all.

(h) ***Quality Preventive and Curative Health Services*****:** Your HMIS shall endeavour to provide both preventive and curative health services to your members. You must understand that enhancing preventive health services becomes more beneficial to your individual members and whole organization in the long run. Your HMIS must be able to balance the provision of this mix of services. Over and above this, your HMIS shall always strive to maintain high quality of these services.

(i) ***Sustainable Operations:*** You must be mindful of ensuring not only the viability of your HMIS but also its sustainability over time. It is therefore necessary for your HMIS to put in place the appropriate management structure, develop capabilities of its leaders and members, institutionalize essential support systems, and generate the needed resources to continuously

run and adequately maintain its operations.

(j) ***Rights-Based Approach:*** Your HMIS must always regard the need and right of your members. As mentioned earlier, your membership must be opened to anyone regardless of race, gender, age or state of health. Each and everyone has the right to participate. Your organizational structure must be set-up to allow all your members to have their opinions and voice heard and participate in deciding the affairs of your HMIS. They also have the right to correct information, hence the need for you to set up mechanisms that they are regularly updated and informed of the developments in your HMIS. Quality health care is a basic human right. You must ensure that your members receive the quality of care they deserve.

(k) ***Gender-Sensitivity*:** Your HMIS must not discriminate anyone regardless of their gender and sexual orientation. It must adjust its services to meet both needs of men and women alike. Vulnerable groups like women and children as beneficiaries of your HMIS must be given due attention. Leadership must be equitably shared among male and female members in your groups. Opinions from male and female members must be considered equally and should be sought with the same degree.

As a scheme of social protection in health, your HMIS must have (a) the appropriate organizational structure, (b) the general membership who pool their resources to respond to their health needs, and (c) the right mix or package of services available to its members. More importantly, it should have the management systems well in place in support to these components.

Section 1.4: Components of a HMIS

1.4.1 Organizational Structure

Your HMIS involves the tripartite partnership of your members, service providers and the managers/ operators of the scheme. There are different organizational arrangements that can be set up but you must decide which structures are best suited to your particular situation or need.

Usually, an HMIS is structured into four essential bodies. You don't have to create all four structures. You may opt to combine duties and responsibilities into one unit only, if you think this is the best structure for your HMIS to be managed and ran.

- General Assembly (GA)
- Board of Directors (BD)
- Executive Body (EB)
- Auditing Body (AB)

In the Philippines where most cooperatives or mutual organization manage health micro-insurance schemes, additional responsibilities are usually given to existing committees in the organization to oversee the operations and management of the HMIS.

Note that these structures are discussed in more detail in the subsequent chapter. What is presented here are their general functions and competencies.

(a) General Assembly (GA) : This is the highest decision-making body of your HMIS. It is the general membership of your HMIS. It determines the general policy of your whole HMIS and its decision is binding on all your members. It is usually convened at least once a year to approve annual accounts and the budget or new programs that will be undertaken or new benefits that will be given to all the members of the scheme or organization.

(b) *Board of Directors (BD):* The BD is the policy-making body and is responsible for the overall management of your HMIS. It exercises all the responsibilities apart from those explicitly assigned by the law or your own By-Laws or Constitution. Your BD constantly monitors the management of the organization. It may delegate part of its responsibilities to the chair or more administrators. But it generally proposes the admission and exclusion of your members to the GA.

(c) *The Executive Body (EB):* This is usually established by the BD and is responsible for implementing the decisions of the GA and the BD. It is in-charge of the day-to-day management of your HMIS. In certain cases, especially in smaller organizations, the EB may come from the BD itself. If your HMIS is large enough, the EB staff are hired and are salaried. The Chair usually becomes a member of the BD to be able to regularly update and inform them of what is happening to the organization. The EB are called differently in the Philippines. Some refer to it as the Project Management Staff. Others call it as the Executive Committee or the Management Committee.

(d) *The Auditing Body (AB):* The AB is usually elected by the GA. Its purpose is to monitor the implementation of the decisions of the GA. Based on the results of their monitoring, the AB can recommend ways to improve the operations and management of your HMIS to ensure more effective functioning and efficient operations. In cooperatives, the AB is called the Audit and Inventory Committee while others call it as the Monitoring and Evaluation Committee.

The following tables summarize the major functions and competencies of the above mentioned structures of your HMIS.

The overall structure of your HMIS depends largely on the size of your members and its geographical coverage. If your HMIS operates only within a given district or a city where your members reside, then your structure may be limited only to one level. Whereas if your membership extends region-wide or nation-wide, then it may be necessary for you to establish organizational structures at two levels or more.

A regional body , if it is formed, can provide several services to your HMIS like advisory support, technical assistance, financial services or a guarantee fund, representation services and promotion services.

You must take note that your HMIS may create additional committees to help carry out its programs and activities. Some HMIS may need to create separate structures like:

- Medical or Therapeutic Committee
- Grievance or Complaints Committee
- Quality in Health Committee

In determining the composition of these different structures, you should ensure that apart from their interest, commitment and competency, there should be a good mix of women and men that ensures substantive representation of the needs and interests according to gender, occupational groups, ethnic identities, age groups, and other similar categories.

1.4.2 Beneficiaries

(a) *Definitions*: A "*beneficiary*" refers to individuals who have the right to your HMIS benefits. Beneficiaries include both your members and their dependents. A "*member*" refers to the one who joins your HMIS, who pays the membership fees, undertakes to observe the rights and duties and pay contributions. He/she is sometimes called the "policy holder." In your HMIS, anybody may join the

organization if he/she has attained the minimum required age, without discrimination of any kind by reason of state of health, sex, race, ethnic origin, religion, philosophical or political views, provided that they observe the By-Laws and the Policies, Systems and Procedures (PSPs) and regularly pay their contributions.

"Dependents," on the other hand, refers to individuals who are directly dependent on your policy holder or member with whom the right of HMIS benefits are extended. The dependents may include the spouse, children up to certain age and orphans who have been officially fostered. Family members however may not be considered dependents unless they are indeed financially dependent upon the policy member. If a child becomes a wage earner herself/himself, then he/she is no longer considered a dependent but must become a policy holder himself/herself.

There are cases where it is difficult to determine the "dependents of a policy holder." Examples are young unmarried persons who continue to live with the policy holder, the parents of the policy holders or the second wife in a polygamous relationship. This suggests that extra care must be exerted to define clearly the parameters that the HMIS considers as qualified "dependents."

(b) *Categories of Members:* Though in principle, membership to your HMIS is not conditional to the state of health of your individual members, your HMIS must take a conscious effort to consider memberships of the older persons, those who are chronically ill or sick individuals or HIV carriers, as they cause financial imbalance especially at the start of your HMIS operations.

Some HMIS have addressed the "older persons" issue by setting a certain age limit for participation, or requiring a higher amount of first time contribution from members enrolling for the first time over a given age. For those with chronic diseases, you must really need to strike a balance between supporting those who are most in need and the survival of your HMIS. Some ways for you to address the issue of your members with chronic diseases are:

- offer payment of drugs only
- set a ceiling of benefits to each beneficiary monthly or yearly
- cover hospitalization only in the acute phase
- set an annual flat rate for each type of disease
- establish an action fund separate from the main fund

(c) *Membership Fees*: With regards to membership fees, ensure that your GA incorporates into your HMIS By- Laws a provision for the payment of membership fees upon registration of a member, and that the fees can be changed periodically. Note that the membership fee is used primarily to cover the cost of the registration process. Thus, it is supposed to be paid only once - at the time the individual joins your HMIS. It is therefore not payable in subsequent years. There are times though that your membership fees may be replaced by the sale of your membership card or book, which is usually more preferred by most members. There are only two possible occasions for more than one-time payment of membership fees. The first is when your membership fee is replaced by the sale of your membership card - the card is purchased at each renewal. The second opportunity is when the HMIS requires the membership fee to be paid again by those who have stopped paying their contributions after a period of over a year or so.

(d) *Membership Contributions*: Your members' contributions are the main source of income of your HMIS.

These should be sufficient to allow your organization to:

(1) grant benefits to your members
(2) finance its operations
(3) build reserves in order to reinforce its financial soundness from one financial year to the next

There are also 4 possible systems for paying the contributions:

(1) your policy holder and his/her dependents each pay the same contributions
(2) dependents pay a lower contribution than your members
(3) two contributions rates are applied with or without dependents
(4) a single contribution is paid, regardless of the number of dependents

The payment system is the decision of your GA and is usually incorporated in the by-laws. The GA can also decide to add a special contribution (e.g. for AIDS), if it is so desires.

(e) Membership Card: The membership card serves two purposes: (a) to identify your member and the other beneficiaries; and (b) serves as evidence that your member and his/her dependents, listed on the card, are entitled to your HMIS benefits. This card may take different forms. It may be a family card, or an individual card (one card per person) or it may take the form of a health record which contains several blank pages on which the health care providers record their procedures and prescriptions. Each card, whatever form it may be, must contain the following information.

- the first name and the surname of each beneficiary (this means your member and his/her beneficiary/ies

Table 1.2: Model Organization Chart of an HMIS

FUNCTIONS	HMIS BODIES
General Policy	General Assembly (GA)
Control and Audit	Auditing Body (AB)
Management	Board of Directors (BD)
Execution	Executive Body

Table 1.3: Competencies of the HMIS Bodies

Competences	GA	BD	EB	AB
1. Adopts and amends by laws	X			
2. Controls the accuracy of accounting and correct handling of financial operations				X
3.Fixes the amount of contributions and of any special payments	X			
4. Decides on criteria for acceptance or rejection of HMIS members	X			
5. Monitors compliance with the HMIS policies, systems and procedures				X
6. Coordinates the work of the different committees		X		
7. Deals with day-by-day HMIS administration			X	
8. Manages the HMIS assets and funds			X	
9.Draws up annual accounts and budget for the next accounting period		X		

- each beneficiary's date of birth
- a family or individual code number which allows the possible tracking of each individual through health care billing or monitoring tools. This number is noted in the register of your members and the code may include other components like the village, group or region where your member belongs
- an indication that the contribution has been paid, usually in a form of a stamp, to show that your member's contribution is up to date

(f) Membership Qualification and Application: Anyone who has reached a minimum age established by the GA and who respects the By-Laws and the PSPs, may apply to become a member of your HMIS. In terms of joining, ensure that each applicant or enrolee undergoes the following:

(f.1) Membership Application: Ask the individual to apply in writing by accomplishing the membership form containing the basic information about him/her and his/her dependents. This is submitted to the GA but is often delegated to the EB.

(f.2) Payment of Membership Fee and Contribution: Once his/her application is accepted, ask him/her to pay the membership fee and the contribution for the corresponding period.

(f.3) Entry on the Registry of Members: Ensure that you enter on the Register of Members every new member of your HMIS, and issue to them their membership cards indicating the date when they become eligible to the benefits.

(f.4) Information to the Member on the Policies and Internal Rules: Upon enrolment, give each applicant a full orientation about your HMIS, By-Laws and PSPs as well as their rights and duties as members. You can support or aid this orientation with flyers containing these rules and policies.

(g) Probationary Period: The new member is usually asked to observe a probationary period established by your organization before becoming entitled to your HMIS benefits. This probationary period refers to the phase in which your new member pays contributions but is not yet entitled to your HMIS benefits. It is otherwise known as the observation period or the waiting stage. Its purpose is twofold: to ensure that people do not join only when they are ill, and to allow your HMIS to build up its financial reserves to cover the costs of benefits to your members. Your new member must respect a waiting period before receiving benefits.

1.4.3 Services

The services offered by your HMIS should correspond to the needs felt and expressed by your target membership. It is essential that the services you offer are matched with their needs, from the time you are still starting your HMIS and throughout its operations over time. You need to regularly evaluate though these services if they continue to be relevant and appropriate to your members' needs and if they are delivered in satisfactory manner.

(a) Choosing the Services to be Offered: The services provided to your beneficiaries are the reason for the existence of your HMIS. It is important that your scheme meets the needs of your beneficiaries, taking into account their ability to contribute and the existence of an adequate supply of care. You must note however, that for each new service your HMIS offers, the contribution of your members may have to be increased. It is therefore advisable for you to strike a balance between the services that meet the needs of your members as closely as

possible, and on the other, the need to fix a contribution level which is accessible to your members.

There are two approaches in identifying the services which your HMIS can offer to your members.

Option 1: Take the available earnings of your HMIS as the basis and establish the corresponding services

Option 2: Identify the priority needs of your members and assess the level of contributions necessary to meet those needs.

If your HMIS is constrained more by the low income of your potential members, then it may be better for you to:

(1) fix a contribution amount that is accessible to your target membership

(2) estimate the number of your potential members and the expected annual income from them

(3) determine the priority services that can be financed by the financial resources available in your HMIS

If on the other hand, the income constraint is less pressing in your HMIS, then it is advisable that you:

(1) assess first the priority needs of your members;

(2) calculate the volume of resources that are needed; and

(3) fix the contribution at a level that will bring in the necessary amount

Note that whatever option your HMIS takes, this will entail a lengthy procedure. Hence, there is a need for you to come up with several scenarios. The ultimate decision should be taken by your GA. One important thing though that you have to bear in mind – is that it is always advisable for you to offer initially a limited number of services. Once your HMIS has gained some experience and that its management system is already in place and fully functioning, then you can expand the number of services to offer.

(b) *Type of Care That The HMIS May Cover:* Generally, it is not possible for your HMIS to cover all health care from the start-up activities. Only part of the care can be taken into consideration, such as primary healthcare, secondary or specialist care, medicines, transport or other social risks. The following gives you examples of health care that your HMIS can cover:

(b.1) Basic Health Care: This package of services is the most common type of care that is usually provided by the health centers or Rural Health Units (RHU), which is the first point of contact between the target membership and the health care system. This package includes:

- preventive and promotional care including pre-natal and post-natal consultations, monitoring of infants' health, vaccination, family planning, health education and counselling

- curative care which primarily includes consultations, nursing care, supply of drugs and some laboratory analysis; sometimes it also includes minor hospitalization in health centers or assisted childbirth
- coverage of chronic diseases like diabetes, high blood pressure, haemophilla, heart diseases, etc.
- coverage of treatment of children suffering from malnutrition and their recovery

(b.2) Hospital Care: This covers both accommodation in the hospital and medical, surgical and technical procedures and drugs consumed.

(b.3) Specialized Care: This includes consultations (gynaecology, obstetrics, surgery) and technical medical treatment such as radiology and clinical biology.

(b.4) Dental Care: Some HMIS reimburse dental expenses, usually tooth extraction, sealant and prophylaxis.

(b.5) Spectacles: There are some HMIS that reimburse the cost of spectacles if they are issued as part of the medical prescription. Most often, the coverage is confined to prescribed lenses and the frames are not covered.

(b.6) Medicines: As far as medicines are concerned, it is important that you list those that will be reimbursed by your HMIS. Given the disparity of prices between branded (proprietary) medicines and generic medicines, it is advisable that you only reimburse the generic medicines if they are available, or the corresponding proprietary medicines on the basis of the price of the generic medicines. You can base the list of proprietary medicines to be covered by your HMIS on those listed in the National Drugs Formulary produced by the Department of Health. Ideally, the medicines should be delivered by the health centers. If this is not possible, the medicines on your list may only be reimbursed if they have been prescribed. In this case, possible abuse is more difficult to counteract.

(b.7*) Transportation of Patients:* In addition to meeting the cost of healthcare, your HMIS may organize and take responsibility for transporting beneficiaries who are ill to a health center or for transferring them to the nearest hospital, in accordance with a referral system (patient transferred to hospital after consulting a health centre).

(b.8) Other Social Risks: Some HMIS also cover other social risks to which their beneficiaries are exposed. Your HMIS may grant lump sum allowances (indemnities) on the occurrence of certain events such as giving birth or marriage. Other social risks that your HMIS may cover include the following:

- incapacity to work following illness or accident (daily allowance)
- invalidity (periodic pension)
- old age (pension allowance)
- death (allowance and funeral services)

(c) *Partial Coverage of Health Expenses:* Your HMIS has the option to cover fully or in part the expenses incurred by your members. You may grant benefits in the form of flat rate, for example the transportation of patients. The following are options for applying partial coverage:

Option 1: Percentage Co-Payment: This means that you deduct part of the total health expense from the amount reimbursed to the member.

Option 2: Flat Rate Co-Payment – In this second option, your HMIS only covers the amount above the pre-determined amount. This is usually applied to certain types of services provided.

Option 3: Ceiling of Benefits (or guarantee)- In this option, your HMIS sets a limit/ceiling of its coverage to a maximum amount for a particular event. This means that the member will be the one to shoulder any cost beyond the set ceiling. This protects the HMIS from exceptionally high expensive cases.

Example: Percentage Co-Payment

If your HMIS shoulders 80% of total expenses in the amount of Php 20,000., or the equivalent amount of Php 16,000, then your member will pay the other 20% or the remaining Php 10,000. This means that the co-payment by your HMIS is 80%. It is expressed in terms of percentage.

Total Expenses Incurred	:	Php 20,000.
Set Percentage of 80%	:	Php 16,000. (to be paid by the HMIS)
Remaining Balance	:	Php 4,000 (to be paid by the member

Example: Flat Rate Co-Payment

If a member incurred a total cost of Php 20,000. for his/her hospitalization and that the predetermined amount is set at Php 8,000., then the HMIS will only pay the amount above Php 8,000, which in this case is Php 12,000. If the member only incurred Php 6,000 for his/her hospitalization, then the HMIS will not pay anything because the pre-determined rate is still higher than the actual cost incurred.

Total Expenses Incurred	:	Php 20,000.
Pre-determined Amount	:	Php 8,000.
Amount Paid by the HMIS	:	Php 12,000.

Example Ceiling Benefit of Guarantee

For example, if the ceiling set to be paid by the HMIS is set at Php 12,000, and the member actually incurred a total amount of Php 20,000, then the member will have to pay the balance of Php 8,000.

Total Expenses Incurred	:	Php 20,000.
Ceiling Set by the HMIS	:	Php 12,000.
Balance to be paid by member:		Php 8,000.

(d) Granting of Benefits to Members: There are two ways by which you can grant the benefits to your members. This is either through the service provider or third party contracted by your HMIS or delivered by the health facility you established on your own.

(d.1) Providers Based on a Contractual Agreement with the HMIS: In this first scheme, there are three parties involved in the payment: your member, your HMIS, and the service provider or third party you contracted. Granting the benefits under this scheme works this way:

(d.1.1) Payment by Members: Your member pays in full the service provider and is subsequently reimbursed by your HMIS. In this case, your member pays according to the mechanism set by the service provider (e.g. fee-for service, case payment or flat rate payment) or arrangements agreed upon with the HMIS. This means that your member must obtain proofs of payment (receipts or invoice) from the provider and bring these to the HMIS for reimbursement.

This scheme is not so good for the members as they need to put up front the whole amount to be paid. Its advantage for the HMIS is that it discourages over consumption and abuse of the system for fraudaulent billing. This however requires more paper work on the part of your HMIS, hence a higher administrative cost.

(d.1.2) Direct Payment by the HMIS: Your HMIS pays the provider directly. In this scheme, you require your member only to pay the co-payment to the provider. Your HMIS pays the remainder of the total bills to the provider directly upon presentation of invoice by the provider.

This scheme is more advantageous for your members since they do not have to make financial resources available and that they are spared from additional formalities and delays in receiving the reimbursement. Your HMIS may have less control through of the service consumed by the members, thus, it may result to over consumption of services and escalating costs.

Sometimes, the two schemes of granting benefits can be combined by having your member pay the third party for minor expenses while your HMIS pays the service provider for major expenses.

(d.1.3) Capitation Scheme: Another way of paying for health services rendered to your members is through the capitation scheme. This requires your HMIS to guarantee a fixed amount to your partner health care provider (e.g. hospital, clinic, etc.) in a given period, usually annually corresponding to the number of your eligible members. During the period, anyone of your eligible members could avail of the services from your partner service provider depending on the terms and conditions agreed upon in your HMIS. The costs of health care are charged to the capitation fee, hence your members do not shell out cash for the services they availed of (except of course for those services not covered by the HMIS). During the year, it is expected that the capitation fund is used up but at other times, it redounds to additional income for the service providers..

This scheme lessens administrative cost and at the same time reduces financial burden on your members.

This capitation scheme is currently practised by the ORT- Health Plus Scheme in San Fernando, La Union. The ORT-OHPS pays the partner hospital – the Ilocos Training and Regional Medical Center a certain amount at the start of the year corresponding to their eligible number of members. The list of eligible members is provided by the ORT-OHPS to the hospital at the time they release the capitation fee. When an eligible member gets sick and becomes hospitalized, the hospital confirms with the ORT-OHPS staff the eligibility of the member. If confirmed positive, the cost is charged to the capitation fund. At other times, the sick member goes to the ORT-HPS first and then is referred and endorsed direct to the health provider.

(d.2) Services Provided by Health Infrastructure Established by the HMIS: The health facilities established by your HMIS provide the services to your members, including non-members alike. Members are given preferential rates over the non-members. It is always advisable that your HMIS observe separate accounting from its established health facility in the interest of good organization and transparency.

There are several means by which benefits are granted to your members through the health centers/RHUs or hospitals established by your own HMIS.

- Members are covered 100% once the probationary period has been completed. In this case, benefits are provided upon presentation of the membership card to the health facility
- Only consultation is free and care and drugs consumed must be paid for by the members
- A flat-rate co-payment is paid by your member for each consultation or procedure.
- Your HMIS applies a percentage co-payment, in which case the member pays a given percentage of the full cost of consultations, care and technical procedures.

In the dispensaries set up by your HMIS, the sale of generic drugs is encouraged. Only when there is no alternative that specialist drugs are provided. In this scheme, you give preferential rates to your members while the non-members may purchase drugs at the market price. A larger reduction may also be granted for generic drugs to encourage their consumption over that of brand name drugs. As additional information in the management or operation of a community pharmacy or "botika sa barangay", you may coordinate with the regional offices of the Department of Health or through the Municipal Health Office of your Local Government Unit. Information on legalities of its operations, how to coordinate with other groups in purchasing medicines to get a more

affordable rate, management of inventory and the like should be gathered.

1.4.4 Management of Major Risks Connected to Health Insurance

All HMIS are faced with certain risks. In this regard, you must take particular preventive measures so that the feasibility of your HMIS is not compromised. The following are the major risks facing any HMIS wishing to offer its services to their target membership as a whole without discrimination:

- the risk of 'adverse selection' or spontaneous pre- selection
- the moral hazard of over-consumption
- the moral hazard of over-prescription
- fraud and abuse
- the occurrence of 'catastrophic' cases

(a) Risk of Adverse Selection: Adverse selection relates to situations where people with a high risk connected to their state of health join your HMIS in large numbers, and when people in good health tend to refrain from joining. This may compromise the financial viability of your HMIS, since it involves too high a level of expenditure per beneficiary. Unlike a commercial private insurance scheme, your HMIS cannot select its beneficiaries or make each of them pay premiums corresponding to their personal risk. There are different ways to minimize this risk:

(a.1) your HMIS demands that the **minimum unit** of admission should be the family

(a.2) in setting up your HMIS, it is advisable for you to enrol all the members of a particular group simultaneously (e.g., members of a company, trade union, group, association or religious community)

(a.3) You may also provide for a **waiting period** or a probationary period. This period is necessary to prevent certain people joining only when they need to, and then opting out afterwards (e.g. membership in anticipation of giving birth).

(b) Moral Hazard of Over-Consumption: The moral hazard is the situation often observed when your members or their dependents tend to abuse the services offered, or use them more than they normally would from the time they are insured. The fact that the contribution is independent of the amout of expenditure met, it encourages individuals to consume a maximum of care to make their contributions worthwhile. The following measures can be taken to reduce this risk:

(b.1) Patient's Contribution: You may establish a cost-sharing scheme between your HMIS and members (for example, the member to pay the remainder over the threshold set for reimbursable cost).

(b.2) Establishment of an obligatory reference system: This entails your HMIS determining the conditions of access to a higher-level of care, which is often more costly. You may require your beneficiaries not to go to the hospital until they have

consulted a general practitioner in a health center, where services rendered are less costly.

(b.3) Establishment of an observation or probationary period: You may demand, particularly in the case of monthly contributions, your members to contribute for a probationary period first (three or six months, for example) before being entitled to the benefits offered.

(c) Moral Hazard of Over-Prescription: Care providers may cause a sudden increase in healthcare costs by prescribing unnecessary treatment without objection from the member-patient simply because they are insured. The following measures may help to minimize this risk:

(c.1) Payment on the basis of a **lump sum or flat rate** per person or per episode of illness

(c.2) Stadardization of treatment schemes and control by your HMIS' medical adviser

(c.3) Obliging providers to prescribe **generic essential medicines** or limiting the reimbursement of certain medicines included in the list drawn up by your HMIS

(c.4) Establshment of **benefit ceilings.** Your HMIS may, for example, decide only to coer a limited number of days in hospital, the remainder being your member's responsibility

(c.5) Establishment of **non-reimbursable days or of flat-rate co-payment** for hospitalization (example, the first day of hospitalisation can be paid for by the patient to avoid non-essential hospitalization

(c.6) Requiring your members and their dependents to adhere to the available **preventive measures** like vaccination in order to reduce the risk

(d) Fraud and Abuse: Your HMIS is exposed to risks of fraud and abuse by your members,particularly when it reaches a significant size. Fraud and abuse are often a result of the pressure that can be exerted on a member by their family, circle of friends or neighbours. Your members may also make a selection within their family by not paying contributions for all their children. For example, when one in the family who is not covered falls ill, there will be a great temptation to pass them off to the service provider as one of those included on the membership card. The following measures can be taken to combat this risk:

(d.1) Ensure that a check is made before treatment is administered: Before beingattended for treatment, your beneficiary should appear first before the administrator of your HMIS, who provide a Certificate of Entitlement;

(d.2) Ensure that a check is made after treatment is administered: You should check whether the members for whom the providers issue an invoice for treatment are really ill during the period concerned. Fraud is not avoided, but it can be remedied and punished

(d.3) *Affix an identity photograph of the member and their dependents on the membership card*: This solution is often costly however, and may limit membership.

(e) *Occurrence of 'Catastrophic' Cases*: This concerns HMIS that cover major risks, without setting a ceiling on meeting the cost. It occurs basically when your HMIS begins its activities: if exceptionally high health expenditure occurs at this time, your HMIS will very rapidly experience a financial crisis.

(e.1) The first response to this risk is to establish substantial financial reserves. Hence, the application of a waiting period before meeting the cost of health expenditure is very critical.

(e.2) Access to a guarantee fund or the possibility of reinsurance.